REQUEST FOR ADOPTION ASSISTANCE PROGRAM BENEFIT

The Adoption Assistance Program (AAP) provides benefits to adoptive parents to enable them to meet the needs of AAP-eligible children who are available for adoption. The AAP benefit is a negotiated amount based on the needs of the child and the circumstances of the family determined through discussion between the responsible public agency and the adoptive parents. The maximum AAP benefit for which a child may qualify is based on what the child would have received in a licensed foster family home if he or she had remained in foster care.

I/We, _____ (NAME OF ADOPTIVE PARENT) and _____ (NAME OF ADOPTIVE PARENT) , am/are considering adopting _____ (NAME OF CHILD) , born _____ (DATE OF BIRTH), My/Our circumstances and the needs of the child are such that I/we will require assistance under the Adoption Assistance Program in order to agree to adopt this child.

Check (✔) one of the following:

☐ After the child is placed for adoption, I/we will require assistance in meeting his or her needs. I am/We are providing the following information to assist the agency in determining whether assistance may be provided, and in what amount. I/We understand that for assistance to be provided, the agency and I/we must agree on the amount, timing and duration of the assistance.

☐ I/We do not require assistance at this time, but wish to complete a deferred agreement with the agency which shall permit such assistance at a later date, due to the child's known medical condition or physical, mental or emotional disability, or other health condition.

1. CHILD'S INCOME

a. This Child's Monthly Unearned Income

Social Security . . . . . $ _____ (MONTHLY)

SSI/SSP . . . . . $ _____ (MONTHLY)

Other . . . . . $ _____ (MONTHLY)

Child's Total Income: . . . . . $ _____ (MONTHLY) X 12 = $ 0.00 (ANNUAL)

2. HEALTH INSURANCE

Does the family have Health Insurance . . . . . ☐ YES ☐ NO

If YES, name of Insurance Plan: _____

Is the child to be covered by this Insurance? . . . . . ☐ YES ☐ NO

If NO, reason: _____

3. OTHER INFORMATION

a. Is the child a Regional Center client? . . . . . ☐ YES ☐ NO

If YES, which Regional Center: _____

4. MONTHLY AAP BENEFIT REQUESTED, IF ANY

Check (✔) the box that corresponds to the benefit you are requesting:

☐ For Basic Care (Food, Clothing, Shelter, etc.)

☐ For care and supervision based on the child's special needs.

☐ Medi-Cal Only.

Please provide a description of your child's special needs and the required extra care and supervision that would qualify him or her for a special care increment.

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5. Please describe the impact, if any, that adopting this child might have on your family circumstances (i.e., lifestyle, standard of living).

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I/We certify through my/our signature(s) that the information provided in this request for adoption assistance is true and correct to the best of my/our knowledge and belief. I/We make this statement under the penalty of perjury and understand that any willful concealment or misstatement of material fact in this request for adoption assistance may subject me/us to the penalties prescribed for perjury in the California Penal Code.

SIGNATURE OF ADOPTIVE PARENT	DATE	SIGNATURE OF ADOPTIVE PARENT	DATE